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Rapid realist literature review

Supporting Evidence Report 2 for the National Evaluation of the Regional Integration Fund

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

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This is the Rapid Realist Literature Review which is one of four documents providing supporting evidence for the Conceptualisation Report of the National Evaluation of the Regional Integration Fund. The Conceptualisation Report synthesises findings from this report, and three others providing supporting evidence – the Framework for Change (Verity and Llewellyn, 2024); the Group Concept Mapping report on conceptualising the Regional Integration Fund (Wallace and Wallace, 2024): and the in-depth Scoping Interviews report (Bryer and Bebb, 2024).

National Evaluation of the Regional Integration Fund

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1. Introduction

1.1 Executive Summary

The Realist Review method was chosen for the literature review element of the evaluation of the Regional Integration Fund as it offers an opportuning for detailed and granular analysis of the existing evidence base. Realist Review offers a specific method for literature reviewing. As opposed to asking whether an intervention works, realist review asks of the published evidence, 'what works, for whom, under what circumstances, and how?' (Jagosh, 2019, 362).

The Rapid Realist Review approach utilises the development of Context, Mechanism, Outcome (CMOs) configurations to develop what is known as programme theory to try and understand the granular and causal detail of specific health and social care policy approaches, in this case that of integrated care programmes.

A protocol was written to guide the review, in which specific research questions were iterated as guidance for the realist review searches and the review as a whole. These questions were:

1. What are the core components of integrated health and social care models and innovations that become sustainable, how, and why, for whom, and to what extent?;
2. How and why do integrated health and social care models and innovations successfully become mainstreamed, for whom, and to what extent?; and
3. What are the core components for the implementation of national government policy and funding schemes for integration/integrated health and social care?

Three databases were made via Excel to track the results of the review, one for each specific research question. 870 papers were identified initially as relevant titles from 11 different literature databases. From this initial review, 58 titles were selected for inclusion on the basis of title alone, and then these 58 titles were analysed by abstract for relevance, which resulted in the inclusion of 34 titles across three different databases, one for each question.

These papers were then analysed through identifying CMO configurations. This meant reading the papers in depth and identifying instances where a Context

triggered a Mechanism which then led to an Outcome. Jagosh outlines the usefulness of CMO configurations, stating that '…the CMO configuration is a useful heuristic, not only for unpacking generative causation but also for coming to a clearer delineation of intervention resources and contexts' (Jagosh, 2019, p.369).

From this stage, Initial Programme Theory (IPT) was developed based on the findings of the review and the CMO configurations. IPT bucket codes were identified for each question, by consolidating discrete CMOs developed from the literature into overarching themes. These were then developed into Consolidated Programme Theory and the implications for RIF are discussed in the final chapter of this report. These include the importance of having a common vision at all policy levels when it comes to rolling out Integrated Care programmes, policies and funds, and the importance of financial autonomy for discrete elements of Integrated Care programmes.

1.2 **Overview**

The Welsh Government has commissioned a partnership between academics across universities and research organisations in Wales and beyond, to deliver the evaluation of the **Health and Social Care Regional Integration Fund** (RIF) (2022-2027), hereafter named as RIF. RIF is a £144.7 million Welsh Government initiative to support the ongoing implementation of Welsh public policy that aims to strengthen an integrated health and social care system, to better meet population needs, and develop six new models of integrated care.

1.3 These government public policy intentions are set out in key legislation and policy strategies, namely, the Social Services and Well-being (Wales) Act 2014 (SSWBA), Well-being of Future Generations (Wales) Act 2015 (WBFGA), and the policy document, A Healthier Wales (Welsh Government, 2018). Moving 'faster' in implementing these intentions is a core thread throughout the RIF. In the Foreword to the RIF Guidance, the three (then) responsible Ministers express the aspiration to 'accelerate our progress to move further and faster to secure the best care, support and outcomes for the people of Wales' (Welsh Government, 2022a, p.2).

1.4 This document outlines the Rapid Realist Review conducted as part of the Evaluation of the Regional Integration Fund (RIF). It outlines the development, approach, and findings of the Review, as well as providing an explanation of the

Realist Review method. The report has been written using the Rameses publication standards for realist synthesis as a guide (Wong et al, 2013). Realist review allows us to conduct an evaluation which is evidence-based and which drills down into granular detail on literature and data. It allows us to ask 'what works, for whom, under what circumstances, and how?' (Jagosh, 2019, 362) in regards to integrated care policy.

1.5 The Welsh Government (WG) has commissioned a partnership led by the Welsh Institute for Health and Social Care, University of South Wales to deliver the national evaluation of the Regional Integration Fund. The evaluation uses a Principles-Focused Evaluation (P-FE) (Patton, 2018) approach. A PF-E is 'context sensitive' and focuses on the ways principles guide the delivery and adaptation of an intervention in particular times, places, and situations. In a P-FE, the evaluative approach is framed around the principles of an intervention.

1.6 Three central questions are addressed in a P-FE evaluation:

- To what extent have meaningful and evaluable principles been articulated? ('Conceptualisation').
- If principles have been articulated, to what extent and in what ways are they being adhered to in practice? ('Implementation').
- If adhered to, to what extent and in what ways are the principles leading to the desired results? ('Realisation')

1.7 The three questions will be the organising structure for the study through which the objectives identified in the specification will be addressed. A range of data collection methods are employed, which include quantitative and qualitative data. We consider a P-FE framework suitable for the evaluation of the RIF based on the inherent principles in the programme, the importance of being 'context sensitive' and the allowance for adaptability and flexibility in delivery. This Rapid Realist Review is one part of this overall evaluation approach.

2. Method

2.1 Realist Review offers a specific method for literature reviewing and for evaluating interventions and public policy. Jagosh states that ‘realist synthesis is a theory-driven approach to assessing programmes, interventions, services, and policies,’ (Jagosh, 2019, 362). As opposed to asking whether an intervention works, realist review asks, ‘what works, for whom, under what circumstances, and how?’ (Jagosh, 2019, 362).

2.2 A Realist approach seeks to identify causation and in doing so identifies components such as mechanisms which trigger outcomes. A protocol was written to guide the realist review with stakeholders and the Study Expert Reference Group. This group was drawn from key organisations and partners in the delivery and implementation of the RIF. It included people who use services and carers who are also part of the Study Co-Design Group. Once this input was received, the protocol was further developed by the RIF evaluation team. Specific research questions were developed to guide the realist review searches and the review as a whole. These questions were:

- Q1. What are the core components of integrated health and social care models and innovations that become sustainable, how and why, for whom, and to what extent?
- Q2. How and why do integrated health and social care models and innovations successfully become mainstreamed, for whom, and to what extent?
- Q3. What are the core components for the implementation of national government policy and funding schemes for integration/integrated health and social care?

2.3 Once the research questions were developed, and the protocol outlined, the study team commenced the searches that formed the basis of the review. The full study protocol is outlined below:

Realist Review protocol

2.4 The Realist Review protocol outlines the research questions, search strategies and other elements of the realist review. This is standard practice when developing a formal literature review such as a realist review or systematic review. The protocol outlines the intentions and methods of the review. This research review has used

six elements of ‘realist search’. This is Booth, Wright and Briscoe’s (2018) reinterpretation of Pawson’s (2006) principles. These elements are included in the protocol below.

Figure 2.1: Rapid Realist Review protocol

Element 1: Formulating search questions	
Review Questions	1. What are the core components of integrated health and social care models and innovations that become sustainable, how and why, for whom, and to what extent? 2. How and why do integrated health and social care models and innovations successfully become mainstreamed, for whom, and to what extent? 3. What are the core components for the implementation of national government policy and funding schemes for integration/integrated health and social care?
Searches	The realist review will undertake iterative searching of academic and grey literature. Databases to be used: ASSIA (Applied Social Sciences Index and Abstracts), British Library EThOS, CINAHL Plus, Cochrane Database, Community Care Inform, Emerald Database, Google Scholar, Health Evidence Canada, Medline, Open Grey, ProQuest Psychology Journals, PsycArticles, PsycINFO, PubMed, Scopus, Social Care Online, Web of Science. In addition to Social Care Online, Open Grey, and Google Scholar, grey literature will be retrieved from Local Authority websites, Third Sector websites, and provided by the evaluation team/Realist Review Group which included Dr Sion Tetlow, Dr Sarah Wallace, Professor Mark Llewellyn, Professor Carolyn Wallace, Professor Fiona Verity.
Element 2: Search strategy **Background search/scoping the literature (to get a feel for the literature).**	
Databases	ASSIA (Applied Social Sciences Index and Abstracts) CINAHL Plus Cochrane Database Emerald Database Medline ProQuest Psychology Journals

	PubMed Scopus Social Care Online Include Google scholar search of strings
Grey literature	Open Grey
Inclusion and exclusion / parameters	30 years, English Language
Element 3: Search strings **Search for Programme theories (to construct an explanation (hypothesis) for how the interventions (models) work within specific contexts.**	
Q1	(Core Components) OR Central Elements OR Key Elements OR Key Principles AND (Models of Care) AND Definitions OR Scope OR Areas of focus (Models of Care) AND Criteria for Success OR Measures of Success OR Challenges OR Barriers OR Enablers AND definitions of MOC (Models of Care) AND Integrated Care OR Integrated Health and Social Care AND definitions of Models of Care
Q2	(Core Components) OR Central Elements OR Key Elements OR Key Principles AND (Integrated Health and Social Care) OR Health and Social Care AND Models OR Innovation AND Implementation OR Application OR Delivery OR Embedding AND Criteria for Success OR Measures of Success OR Challenges OR Barriers OR Enablers AND Diversity AND Inclusion
Q3	(Core Components) OR Central Elements OR Key Elements OR Key Principles AND National Programmes OR National Policy OR National Frameworks AND Regional Plans OR Local Plans OR Local Implementation OR Regional Implementation (Models of Care) AND National Policy OR National Framework OR National Strategy OR Integrated Care OR Policy Framework OR Health and Social Care AND Success of OR Impact Of OR Parameters Of OR Integrated Health and Social Care OR Health and Social Care Integration OR Health and Social Care Pathways

	AND Integrated Care OR Integrated Health and Social Care AND Citizens Voice OR Carer Voice OR Public Involvement OR Co-production OR Person-Centred
Element 4: Search for empirical evidence **To identify research literature to test the initial programme theory.**	
Types of study to be included	All types of study will be eligible for inclusion. International peer-reviewed articles including randomised, quasi-randomised and non-randomised, with or without a control group; Qualitative studies; Cohort studies; Observational studies; Doctoral theses. Published and un-published grey literature, policy documents, evaluation studies, reports, will be limited to UK only. Restrictions: General discussion and opinion papers, comments and letters, book chapters and conference papers. These documents were excluded as we felt that the most pertinent evidence would most likely be available via the documents included in the inclusion criteria above, rather than general discussion papers, book chapter or conference papers.
Condition or domain being studied	Integrated health and social care models and innovations, successful implementation, and government policy. This could be in the form of papers on models of care, national policy initiatives, national policy frameworks, organisational reports, academic research articles, systematic reviews and case studies.
Participants / Population	Health and social care organisations, service users, carers, citizens, frontline workers, operations managers, senior managers, commissioners, ministers.
Intervention(s), exposure(s)	The realist review will include studies of any integrated health and social care models and innovations being implemented within the UK and globally in English speaking countries.
Context	Studies of any integrated health and social care models and innovations in the UK and globally (English language articles only), studies of innovative integrated care practice UK and globally.
Main Outcomes	The review will identify Context/Mechanism/Outcome Configurations (CMOCs) leading to the development of a program theory (Pawson & Tilley, 1997) that explicates the ways in which integrated health and social care models and innovations have been successfully implemented and delivered. The programme theory will determine the core components of integrated health and social care models and innovations and the criteria for success (how and why do they

	work, for whom, to what extent, and within what circumstances) to become sustainable, mainstreamed, implemented, and delivered. The review will be undertaken in the context of the RIF six models of care: Community based care – prevention and community coordination. Community based care – complex care closer to home. Promoting good emotional health and well-being. Supporting families to stay together safely, and therapeutic support for care experienced children. Home from hospital services. Accommodation based solutions. The programme theory synthesised by this review will then be used to identify how models of integrated care have been successfully (or unsuccessfully) implemented, for whom, how, to what extent and within what circumstances.
Measures of effect	N/A
Additional outcomes	N/A
Data extraction (selection and coding)	Selection: Titles retrieved from searches will be screened in the first place by one reviewer (reviewer 1) for relevance; any titles regarded extraneous will be removed at this stage. Reviewer 1 will review abstracts of the remaining papers in order to determine if they meet the inclusion criteria. In circumstances where it is uncertain if the abstract meets the inclusion criteria, the full text will be reviewed. Abstract screening will be undertaken by reviewer 1 and reviewer 2; reviewer 3 will ensure inter-rater reliability by screening a random 10% of the overall abstracts. Reviewers 1 (ST) and 2 (SW) will review all remaining full text documents in order to outline the final dataset for inclusion. Any disagreements will be resolved through consideration and deliberation with the project team. Data Extraction: Data will be extracted by reviewers 1 and 2. Data will be extracted relating to the study design, context, intervention, mechanisms, and outcome. As above, a random 10% sample of papers will be reviewed by reviewer 3, any disagreements resolved through consideration and deliberation with the project team.

	Data Coding: Context, mechanism, and outcomes formations will be coded to support the progression of a developing programme theory.
Risk of bias (quality) assessment	The RAMESES Standards for Realist Syntheses (Greenhalgh et al, 2013) will be utilised to appraise studies of their relevance and methodological rigour. The documents screened will be judged based on their relevance to the review questions, the developing programme theories, and any bias that may be identified. Reviewers 1 and 2 will review studies, and any disputes or disagreements will be assessed by reviewer 3. The findings of the review team will be shared with the RIF evaluation team in regular monthly meetings for feedback and assessment.
Strategy for data synthesis	Context (C) Mechanism (M) and Outcomes (O) will be identified for each paper that reaches full text extraction stage, and once the review searches are complete and the texts for inclusion identified, CMO formations will be used to develop 'if…. then' statements which outline contexts and mechanisms in relation to the review questions. Once this has been done, a programme theory can be outlined using this data.

Databases and registers: tracking the results

2.5 This section encompasses Elements 5 and 6 mentioned above.

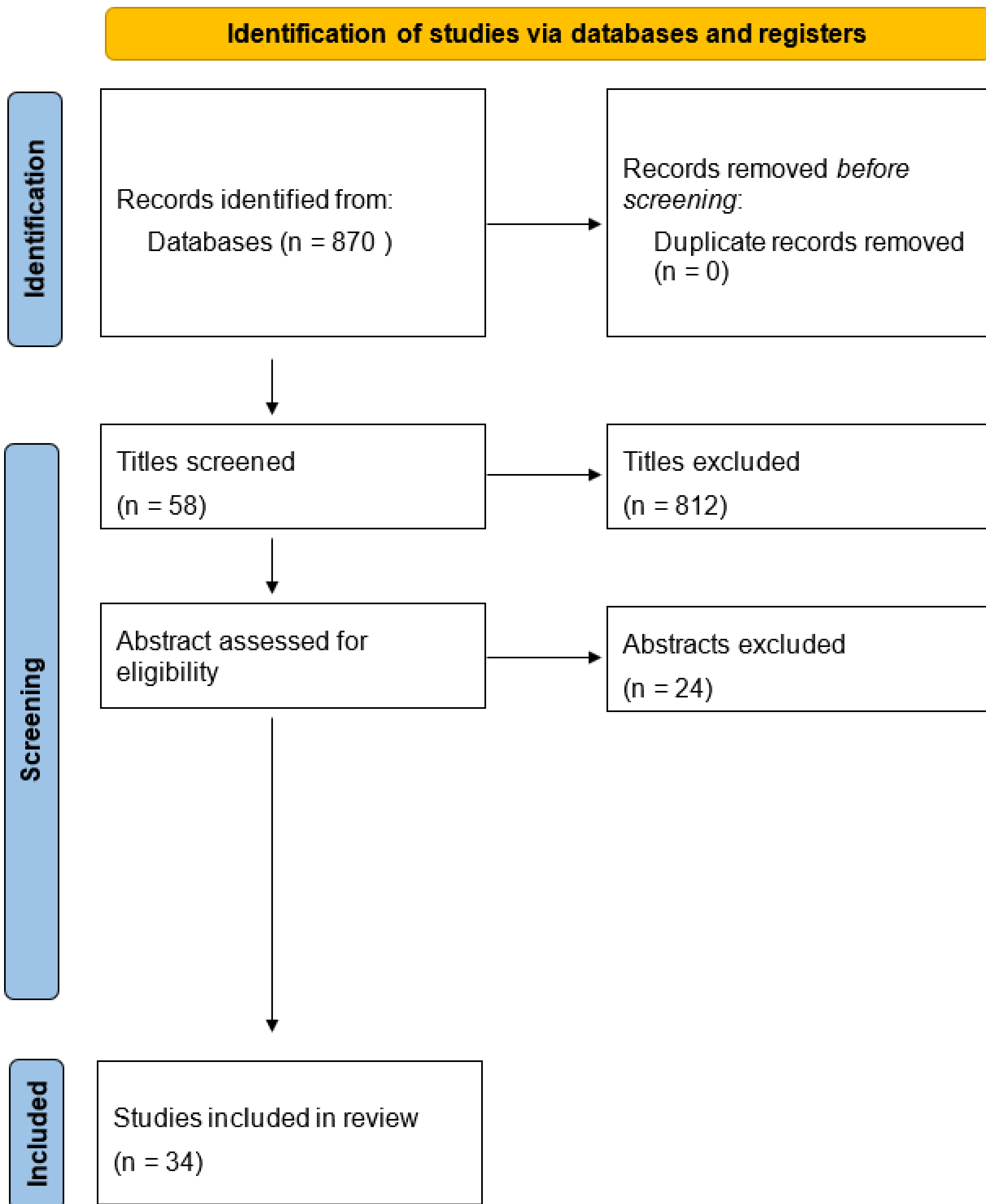
Element 5: Final search to refine programme theories. To link programme theories across disciplines and to relevant mid-range (CMOCs) theories.

2.6 Once the protocol was designed and the search strategy was in place, we set about constructing databases to record our results. Three databases were made via Excel to track the results of the review, one for each specific research question (see Appendix 2 for an excerpt of the database). A PRISMA diagram outlining the exact numbers across all three databases is included overleaf:

Element 6: Documenting and reporting the realist search. To ensure that users are provided with necessary information to assess quality and rigour.

2.7 As can be seen from the PRISMA diagram, we identified 870 initial relevant titles from 11 different literature databases. From this, 58 titles were selected for inclusion on the basis of title alone, and then these 58 titles were analysed by abstract for relevance, which resulted in the inclusion of 34 titles across 3 different databases, one for each question. These papers were then analysed as described below.

Figure 2.2: PRISMA Diagram



2.8 At this point, CMO configurations were developed. The Realist Review method is grounded in generative causation, meaning that it identifies a relationship between the intervention Contexts, its Mechanisms and Outcomes, to develop CMO configurations. Pawson and Tilley state that realist evaluators 'will always construct their explanations around the three crucial ingredients of any initiative (C) context

(M) mechanism (O) outcome,' (Pawson and Tilley, 1997, 77). They go on to say that 'the task of a realist evaluation is to find ways of identifying, articulating, testing and refining conjectured CMO configurations,' (Pawson and Tilley, 1997, 77). This also means appreciating the impact of interventions and in what context interventions work (Davies et al, 2023; Emmel et al, 2018).

2.9 This meant reading the papers in depth and identifying instances where a Context triggered a Mechanism which then led to an Outcome. Jagosh outlines the usefulness of CMO configurations, stating that 'the CMO configuration is a useful heuristic, not only for unpacking generative causation but also for coming to a clearer delineation of intervention resources and contexts,' (Jagosh, 2019, 369). These CMO configurations were developed where the text specifically spoke to the research questions outlined in the protocol.

2.10 From this stage, Initial Programme Theory (IPT) was developed based on the findings of the review and the CMO configurations developed consequently. Programme theory is 'commonly defined as the set of assumptions of programme designers (or other actors) that explain how and why they expect the intervention to reach its objectives and in which conditions' (Marchall, Kegels and Van Belle, 2018 p83).

2.11 For each question, discrete CMOs developed from the literature were consolidated into overarching 'bucket codes', that may reflect a context, mechanism, outcome of any combination (Davies et al, 2023). Initially the bucket codes remain very broad but are a useful stepping stone when transitioning from analysis to synthesis. They also describe the 3 steps of data analysis as 1) 'careful observation of the data' to inductively generate codes, 2) initial programme theory codes or propositions are tested in a deductive manner against the data to build CMOCs 3) using 'retroductive reasoning' and the researchers own insights to abductively identify causal mechanisms. The IPT and Consolidated CMOs are outlined in the findings chapter of this report.

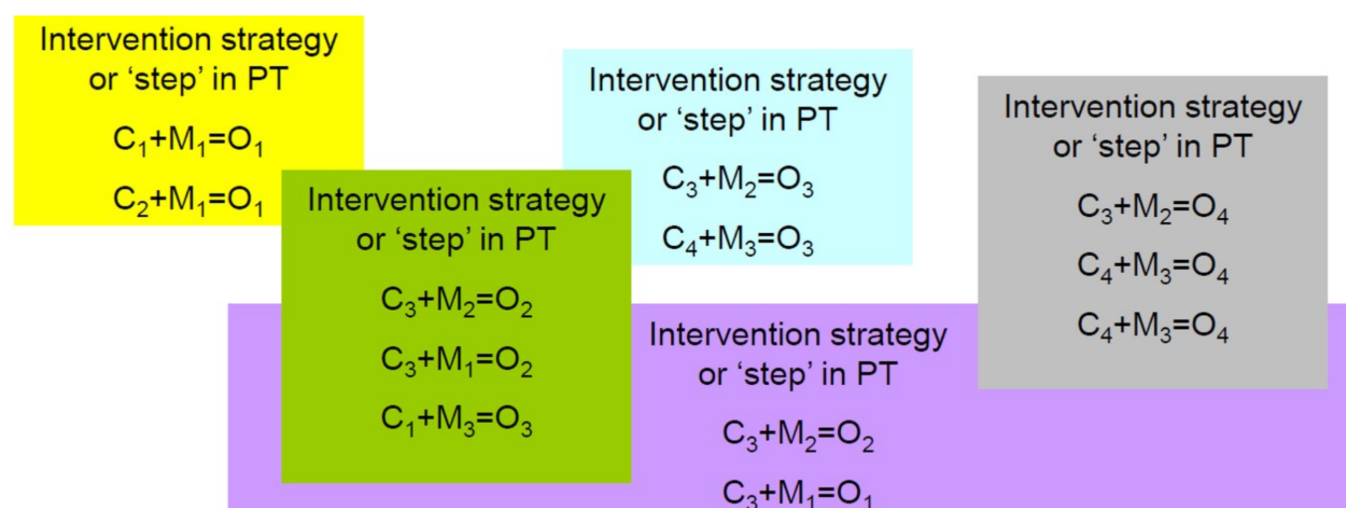
3. Findings

Initial programme theory and consolidated context, mechanism, outcome configurations

3.1 An Initial Programme Theory (IPT) was developed for each of the three questions for this Realist Review, and these are depicted in the tables below. Programme theory is defined as ‘an explanation of how and why an intervention is expected to work and is often expressed as Context Mechanism Outcome (CMO) configurations,’ (Coleman et al, 2020, 2).

3.2 Figure 3.1 below provides a diagrammatic representation of a refined programme theory. This figure outlines CMO configurations within a specific strategy or step or code in the programme theory. The initial programme theory provides a starting point for the evidence review. It may be linear but not necessarily. It is refined iteratively as the review progresses, based on the evidence provided. For the purposes of this report, as noted above, bucket codes were developed from discrete Context Mechanism Outcome formations found in the literature.

Figure 3.1: Diagrammatic representation of a refined programme theory (Wong et al., 2013)



3.3 These codes were then consolidated into an Initial Programme Theory, outlined below and specific to each of the three research questions (see Tables 3.1-3.3).

Table 3.1: Q1 – What are the core components of integrated health and social care models and innovations that become sustainable, how and why, for whom, and to what extent?

IPT CODE	ELEMENTS OF IPT
AUTONOMY AND SUSTAINABILITY	Networks based on professional autonomy
	Fiscal autonomy
	Sustainability of Integrated Care via autonomy of discrete components of Integrated Care (IC) structures
CO-LOCATION, COLLABORATION, COMMUNICATION	Co-location of health and social services
	Importance of face-to-face interactions with workforce and patients/clients
	Open communication based on equality and 'what matters' conversations
COMMON VISION	Assigning equal importance to service users' needs
	Creating a holistic environment
	Sharing strategy and vision
	Engagement in community, business and clinical environment in the region or locality where services are based
BARRIERS TO INTEGRATED CARE	Barriers to progressive reforms sometimes found in national regulatory policies
	Effectiveness-efficacy gap – inability to generalise effectiveness found in controlled setting to real world scenarios
QUALITY OF EVIDENCE	Embedding process evaluations and logic models for IC evaluations strengthens evidence

3.4 The IPT for question one was based on 5 consolidated CMOs developed from the 13 CMOs identified for question one. CMOs were consolidated by finding overarching codes in the CMOs and consolidating these under a bucket code heading. Each consolidated CMO is discussed under the following headings: Autonomy and Sustainability, Co-Location, Collaboration, Communication, Common

Vision, Barriers to Integrated Care, and Quality of Evidence. The elements of the IPT listed on the right of the table are some of the examples of the CMOs that make up these consolidated CMOs. These will be discussed further in the chapter.

Table 3.2: Q2 – How and why do integrated health and social care models and innovations successfully become mainstreamed, for whom, and to what extent?

IPT CODE	ELEMENTS OF IPT
SYSTEM INTEGRATION	Co-ordination of back-office support functions across all units results in functional integration
	Integrated treatment programmes for co-occurring mental health and substance misuse disorders were successful
COLLABORATION BETWEEN DISCRETE PARTS OF HEALTH SECTOR	Secondary care specialists interacting face-to-face with primary care physicians resulted in effective teamwork
	Coaching by experts to strengthen health professionals' diagnostic capabilities
	Specialists become a part of the total health system resulting in improved referrals and communication
PERSON-CENTRED INTEGRATED CARE	Core components of person-centred integrated care: IC must be culturally responsive
BARRIERS TO INTEGRATED CARE	Implementation of a National Programme led to breakdown in contract negotiations with GPs.
INTEGRATED CARE DATA	Integrated care data systems in hospitals
	Integrated health and social care data
	Audit of falls data offered enhanced understanding of patient cohort

3.5 The IPT for question two was based on five consolidated CMOs developed from the overall 23 CMOC configurations for question two. The consolidated CMOs for this question fell under the following headings: System Integration, Collaboration between discrete parts of the Health Sector, Person-Centred Integrated Care, Barriers to Integrated Care, and Integrated Care Data. Again, the elements of IPT give some examples of some of the detail from the CMOs that went into

constructing these consolidated CMOCs. These will be discussed further on in the chapter.

Table 3.3: Q3 – What are the core components for the implementation of national government policy and funding schemes for integration/integrated health and social care?

IPT CODE	ELEMENTS OF IPT
NATIONAL, REGIONAL AND LOCAL INTEGRATED CARE POLICY	Generalising successful local and regional IC programmes to a national level
	Use of wide range of science, policy and practice expertise in developing national IC policy
	Standardising innovation on national levels
	Codifying complex interventions for those who have to implement them
BARRIERS TO INTEGRATED CARE	Lack of evidence supporting integrated care causes service providers to be reluctant to commit their resources to them
INTEGRATED CARE FRAMEWORKS	Framework for sustained uptake of IC service innovations more likely to facilitate the embedding of research evidence into clinical practice
	Reconciliation of system and individual responsibilities
	Development of Communities of Practice
	Use of change management principles

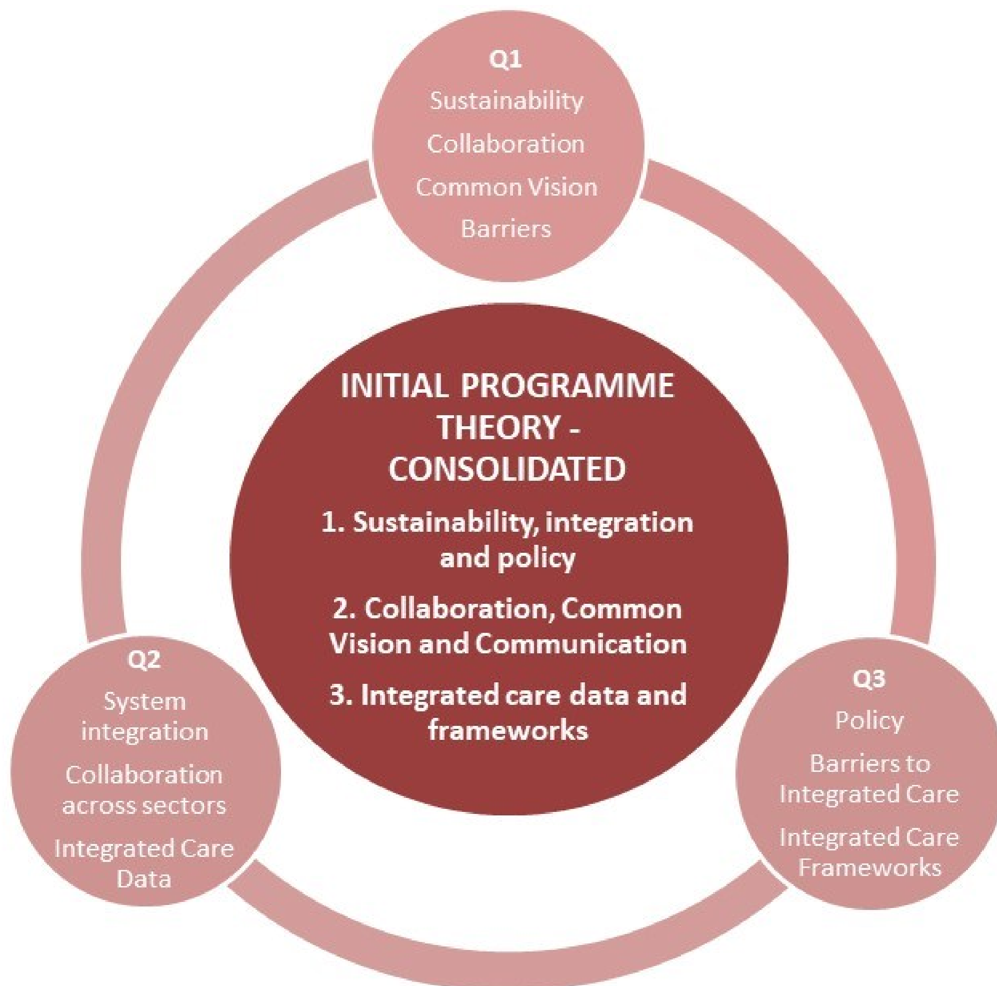
3.6 The IPT for question three was based on 3 consolidated CMOs which were based on 16 individual CMOC configurations developed as part of the analysis. The consolidated CMOs fell under the headings of: National, Regional and Local Integrated Care Policy, Barriers to Integrated Care, and Integrated Care Frameworks.

Relationship between codes from Realist Review Questions 1-3 and Consolidated Initial Programme Theory (IPT)

3.7 The graphic below shows the ways in which the individual IPT formations for each question have been consolidated into an overall IPT for all three questions. The key overall codes when consolidated are:

- Sustainability, Integration and Policy
- Collaboration, Communication and Common Vision
- Integrated care data and frameworks

Figure 3.2: Relationship between codes from Realist Review Questions 1-3 and Consolidated Initial Programme Theory (IPT)



3.8 These consolidated codes outline the core components of integrated care policies, programmes and funds as set out in the literature reviewed in this realist review and are discussed further at the end of the next section. The detail of each IPT for the individual questions are also discussed in the next section.

Bucket Codes and Elements of Initial Programme Theory

QUESTION ONE: What are the core components of integrated health and social care models and innovations that become sustainable, how and why, for whom, and to what extent?

3.9 The core components of integrated health and social care models were identified as Autonomy and Sustainability, Co-Location, Collaboration and Communication, Common Vision, and Quality of Evidence. These core components are discussed in detail in the analysis below. We also identified some of the barriers to sustainable integrated care which are explored in this section.

Autonomy and Sustainability

3.10 There were four CMO configurations that made up this consolidated CMO. CMOQ1R4 (these codes are included in the annex) was developed from Rasku et al (2019). This paper identified that integrated care networks rely on networks based on professional autonomy, which subsequently allowed team workers' roles and scope to be clear in integrated care (IC) programmes, and this ensured efficient collaboration between care providers, which made the IC programmes themselves more sustainable.

3.11 It was clear from CMOSQ1R5-Q1R7 the importance of autonomy in the paper by Embuldeniya (2021); autonomy of discrete parts of an IC system, autonomy of individual hospitals within IC programmes and the importance of fiscal autonomy when delivering IC. These aspects of autonomy, professional autonomy in IC networks, and autonomy of discrete parts of IC system, are all key parts of what make IC programmes sustainable in the long term.

Co-location, Collaboration, Communication

3.12 There was a total of four discrete CMOs that made up this consolidated CMO on the importance of co-location, collaboration, and communication. These were CMOs Q1R9, Q1R12, Q1R14, and Q1R15, across three different papers: Paper 4 by Klinga (2018), Paper 5 by Baltaxe (2022) and Paper 7, Michielsen (2021) for Question 1. It was apparent in the paper by Klinga (2018), that there was an attempt to foreground practical interdisciplinary teamwork in a steering group for a Swedish mental health integrated care policy in a Swedish locality.

3.13 This then triggered a decision to co-locate all health and social services in co-run centres, which then enabled sustainability due to continuous learning and service

integration. The paper by Michielsen (2021) highlighted the importance of communication in person-centred integrated care (I. Seeking to foreground interprofessional communication in a person-centred IC programme, healthcare organisations improved their communication skills towards external organisations which then lead to improved professional communication in this person-centred IC programme. These aspects of co-location, collaboration and communication can be seen as key core components to sustainable IC programmes.

Common Vision

3.14 The Common Vision consolidated CMO was made up of two discrete CMOs from the realist review, Q1R10 and Q1R13, from Paper 4, by Klinga (2018) and Paper 6, by Oprescu (2023) for Question 1. From the paper by Klinga (2018) it was apparent the importance of sharing a common vision, which in this instance was around giving equal importance to all service users' needs across medical, psychological, and social domains. This allowed practitioners to develop a shared holistic view on service users . This holistic view meant appreciating the complexity of individual patients' health issues. This then enabled the creation of a shared vision and strategy formulation. This shared vision and strategy went on to set the direction for the organisation and its priorities.

Barriers to Integrated Care

3.15 This consolidated CMO was present across all three research questions, highlighting that there are barriers to IC that need consideration. For Question 1, this consolidated CMO was developed from two CMOs, Q1R8 and Q1R11, across Paper 4, by Klinga (2018) and Paper 5, by Baltaxe (2022). In the paper from Klinga (2018), one of the barriers to integrated care was found to be an attempt to change the language around integrated care, an integrated care programme sought to change the language from 'patient' to 'customer'.

3.16 However, this was dismissed due to national regulations which precluded the use of this language and therefore the previous term of patient was kept in use. This paper shows the shift and diversity of language across different sectors, from the health sector to a business sector term which was then rejected by health regulators.

3.17 Baltaxe (2022) presented the issue of the efficacy-effectiveness gap. This occurred when evidence-based benefits of a clinical intervention discovered in a highly controlled setting (efficacy) cannot be generalised to a real-world scenario

(effectiveness).This is a major obstacle in demonstrating health value generation of IC programmes.

QUESTION TWO: How and why do integrated health and social care models and innovations successfully become mainstreamed, for whom, and to what extent?

3.18 This section of the chapter explores the IPT bucket codes for the second question which was around the mainstreaming of IC, looking at the overall bucket codes and the CMOs that make up the larger consolidated CMOs. In answering this question, we identified specific IPT bucket codes that indicated how IC becomes successfully mainstreamed. These involve system integration and collaboration between discrete parts of the health sector.

3.19 There was literature that spoke to person-centred integrated care, and the use of integrated care data in delivering IC services. Barriers to successful mainstreaming of IC were also identified, including breakdowns in GP contract negotiations, which speaks to the issue of top-down IC implementation being resisted by individual parts of the IC system.

System Integration

3.20 This consolidated CMO and IPT bucket code was made up of four discrete CMOs developed from three separate papers. These were Paper 1 by Cheng and Catallo, (2016), Paper 2 by Erskine et al (2018) and Paper 4 by Cheetham, (2023). In Cheng and Catallo (2019), the authors investigated the characteristics of specific domains of IC. They found that where IC programmes co-ordinated back office and support functions across all of their units, functional integration occurred within these IC programmes.

3.21 This paper also highlighted specific characteristics that were key to IC success, one of these being the use of patient centred approaches and the use of typical patient case profiles in designing care and delivery. These case profiles are templates for a patient profile used to design and develop integrated care services. Embedding these practices in IC programmes contributed to successful system integration and more successful integrated health and social services structures and systems.

Collaboration Between Discrete Parts of the Health Sector

3.22 Four discrete CMOs made up this consolidated CMO and IPT bucket code, taken from Paper 3 by Vester (2019), Paper 13 by Shaligram (2022), and Paper 16 by

Huang et al (2014). Vester et al (2019) describe the implementation of the Support Consultation, an IC programme designed to improve communication between cardiologists and general practitioners and to lower the instances of non-acute cardiac referrals to secondary care. Here it was clear that the assignment of a specific secondary care cardiologist to a specific primary care GP surgery, along with their four weekly face-to-face visits to that surgery, ensured effective teamwork due to a closed-loop communication and atmosphere of mutual trust.

3.23 It was also evident in the same paper that the coaching received by GPs from cardiologists resulted in a net saving of 61% due to this new model and a strengthening of the GP cardiac diagnostic capability. These collaborations between specific discrete parts of the health sector are pivotal in mainstreaming IC programmes. Though typically we think of integrated care as the integration of health and social care, this paper shows us that integrated care is not only integration across health and social care but also integration within discrete elements of the health sector, in this case primary care and specialist clinicians.

Person-Centred Integrated Care

3.24 This consolidated CMO was made up of two discrete CMOs taken from paper five (Burdett and Inman, 2021). They investigated the core components of person-centred IC programmes. They found that one core-component is co-ordinating IC in a culturally responsive way. This would lead to individualised care that is reactive to the needs of a defined population. They also found that the creation of dementia-friendly pharmacies strengthened the person-centred approach of specific IC programmes by creating ‘enabling environments that respect dignity’ (Burdett and Inman, 2021, 364).

Barriers to Integrated Care

3.25 Two discrete CMOs made up the consolidated CMO of ‘Barriers to Integrated Care’, and as noted earlier this is a bucket code that was present across all three questions. The discrete CMOs that made up this bucket code were taken from Paper 6 by O’Neill (2022) for Q2 and Paper 14 by Hughes et al (2020) for Question 2. The paper by O’Neill (2022) showed that during the implementation of National IC Programme for Diabetes, the breakdown in GP contract negotiations meant that GPs perceived the new programme as undermining their practice and resources. This illustrates the importance of autonomy in IC programmes and the ways in

which practical implications of IC programmes can sometimes undermine specific elements of the programme, in this case GP surgeries.

Integrated Care Data

3.26 The final consolidated CMO for question two concerns the use of data in integrated care. This CMO was made up of five discrete CMOs taken from two papers, Paper 7 by Muirhead (2016) and Paper 12 by Kaehne (2019) for Question 2. Muirhead (2016) describes the success of the Derbyshire Digital House of Care initiative, which was created to test the concept of integrating health and social care data.

3.27 One example of this was looking at a particularly costly cohort of individuals suffering from falls, whose care pathways were explored prior to their A+E presentations. As a consequence of this work, the Derbyshire Health and Social Care community embraced integrated data more fully, and this contributed towards greater dissolution of organisational boundaries, leading to opportunities for the evaluation and commissioning of services in a joined-up way.

3.28 Paper 12 by Kaehne (2019) described the explosion of ‘Big Data’ and what impact this can have on IC programmes and their use of data. Kaehne suggests that ‘Big Data’ is ‘the current explosion of available data,’ (Kaehne, 2019, 249) in health care services. One option presented by Big Data, is that it allows for model development to occur simultaneously to testing of IC programmes, which, in turn, allows researchers and designers to adjust models flexibly.

3.29 The author states that ‘the key advantage of the latter is the flexibility it affords researchers to adjust models of the intervention, adding or removing variables as their relevance or irrelevance becomes apparent,’ (Kaehne, 2019, 253). It would appear from this consolidated CMO that the use of data in developing and delivering successful IC programmes is a core component of mainstreaming IC programmes.

QUESTION THREE: What are the core components for the implementation of national government policy and funding schemes for integration/integrated health and social care?

3.30 Interactions between national, regional, and local policy bodies and service providers were core components of integrated care for the implementation of national integrated care government policies. One way of successfully implementing

national IC policy was to base policy on successful local and regional IC programmes. We also saw that standardised integrated care frameworks and the reconciliation of system and individual responsibilities facilitated a move to successful national government IC policy.

National, Regional and Local Integrated Care Policy

3.31 This consolidated CMO and IPT bucket code is made up of eight discrete CMOs across four different papers. Two of these papers are discussed in depth here. Paper 1 by Hatano et al (2017), explored the impact of a local integrated care programme in Mistugi province in Japan, and its impacts on the implementation of community-care slowed the growth of healthcare costs in that area. Because of these achievements, national policy makers noticed the success of this IC programme and applied it on a national level.

3.32 Paper 7 for this question by Bhattacharyya (2020) identified that characterising integrated care innovations in a standardised fashion can improve policy on IC. This is because the standardisation allowed the authors to 'identify consistencies and variations' (Bhattacharyya, 2020, 690) in integrated care policy. This standardisation can create a common language that allows policy makers to better understand reforms and innovations designed to improve integrated care.

3.33 It is clear from this consolidated CMO the ways in which local and regional IC programmes can impact national IC policy, and the ways in which IC policy is communicated is also a key component of constructing national IC policy.

Barriers to Integrated Care

3.34 As with the previous questions, the theme of barriers to IC was again present. For this consolidated CMO there was only one CMO present, but due to the prevalence of this code across all questions it was decided that it should nevertheless be included.

3.35 The paper by Foley (2023), highlighted the ways in which lack of a robust evidence base for integrated care in some areas can be a barrier to integrated care implementation. The authors found that in the implementation of integrated care in mental health and substance misuse services, service providers felt that the evidence base for integrated care was not comprehensive. This meant service providers were reluctant to commit their resources to integrated care due to a lack of evidence. This points to the importance of developing a robust and

comprehensive evidence base for integrated care across a variety of specific medical and social care disciplines.

3.36 This bucket code of barriers to integrated care, across all three IPT formations for the research question, has a common thread. This thread speaks to the issues of communication between policy implementation of IC and discrete parts of IC, and the occasional lack of trust of the evidence base for IC by specific service providers.

3.37 It was shown earlier that breakdown in contract negotiations for GPs caused a barrier to a specific IC programme, and this speaks to the importance of having a common vision across all elements of IC policy. This common vision needs to be shared from the national level right down to the local level and for specific service providers. All elements of the IC chain and network must share a strategic vision of an IC policy for it be successful and sustainable.

Integrated Care Frameworks

3.38 The final consolidated CMO, Integrated Care Frameworks, was based on six discrete CMOs, across four different papers (see Consolidated CMO table in Appendix 1). We see from the paper by Foley (2023) the development of a framework for the uptake of IC which was driven by frontline staff with support from patients and management. This framework for sustained uptake of IC service innovations was more likely to facilitate the embedding of research evidence into clinical practice and improve IC frameworks in general.

3.39 Sanderson et al (2023) found that the reconciliation of individual and system responsibilities caused a shift from competitive to collaborative working which meant that the overall system framework was improved. It was also apparent from Billings (2020) that the activities of communities of practice within the New Care Models IC programme – groups for Multispecialty Community Providers for sharing good practice and professional experiences in delivering integrated care - helped to broker and sustain developing IC relationships. This shows the impact that communities of practice can have on IC programmes.

Consolidated Initial Programme Theory

3.40 Referring to the consolidated IPT graphic (Figure 3.2) from the previous section, when the issues across each question are consolidated, we have three clear codes:

- Sustainability, Integration and Policy

- Collaboration, Communication and Common Vision
- Integrated Care Data and Frameworks.

3.41 For the first consolidated code, Sustainability, Integration and Policy, the bucket code of Sustainability from the Question One IPT was combined with the bucket code of System Integration from Question Two IPT and the National Policy bucket code from Question Three. This consolidation was done using the research team's judgement on how best to combine and consolidate the bucket codes, using Realist Review standards as a guide. This consolidated code can be seen to be structural in nature, which means that the code identifies structural and system components of IC policy. This code looked at the ways in which integration and policy for integrated care can impact sustainability long term.

3.42 The second code of Collaboration, Communication and Common Vision consolidates the individual bucket code of Collaboration from question one, Common Vision from question one, and Collaboration in the Health Sector from question two. This consolidated IPT code centres broadly around multi-agency working and the importance of all elements of an integrated care programme or initiative sharing a common vision.

3.43 The third consolidated code of Integrated Care Data and Frameworks speaks to the importance of collecting and evaluating integrated care data in order to achieve effective integrated care practice and policy. This code centres around the bucket codes measuring and evaluating integrated care, using IC data and evaluation frameworks to analyse the effectiveness of IC programmes and practices. This emphasises the importance of robust evaluative data collection methods in IC programmes in order to ensure they operate efficiently.

4. Discussion: Implications for RIF

4.1 We can see from the findings above many of the important components of successful integrated care programmes, as well as some of the barriers to success. The importance of autonomy, particularly fiscal autonomy of discrete elements of integrated care programmes, was seen as hugely important in the IPT for the first research question. This speaks to RIF, because RIF is an integration fund rather than a specific health or social care integration programme. Another bucket code relating specifically to RIF is the importance of a common vision in integrated care programmes. The importance of sharing common vision, strategically and within service delivery, is a key part of what makes integrated care sustainable.

4.2 This also leads into another key IPT bucket code, from question two, which is the use of integrated care data to lead and inform integrated care programmes. To what extent is data on integrated care being used to inform RIF, and to what extent is data on integrated care being collected by services funded by RIF? Additional research anticipated as part of this evaluation includes the Group Concept Mapping exercise, the qualitative interviews, and the Social Return for Investment exercise. These exercises and their findings will allow the IPT to be tested against these findings to either reaffirm or refute its current formation. IPT is an iterative theory that may change over time, depending on factors that come from other elements of the evaluation methods.

4.3 It is also key to consider the one bucket code that was present across all three IPT formations for the three research questions; barriers to integrated care. Numerous barriers were apparent, from issues surrounding the lack of robust evidence for IC meaning that service providers were reluctant to implement it, to the lack of common vision across national, regional and local sites. We saw how some IC attempts to change language in IC programmes fell short of the expectations of national regulations, and we also saw the efficacy-effectiveness gap (Baltaxe, 2022), which discussed the difficulties in generalising findings in highly controlled settings to real world IC scenarios. All of these have implications for RIF and for projects funded by RIF, particularly issues around the common vision of national policy being accepted and delivered by regional and local service providers.

4.4 Finally, the IPT bucket code of National, Regional and Local Integrated Care Policy speaks to RIF most pertinently, as it shows the ways in which national integrated

care policy has been successfully implemented and formulated. The literature suggested that scaling up successful local and regional IC models to a national level could be one way of successfully implementing IC. We also saw the importance of standardising integrated care policy and innovation on national levels. This speaks also to the theme of common vision as well. Similarly, the positive impact of codifying complex interventions for national IC policies was an important component of successful IC policy formulation and delivery. Overall, we can see from this review that embedding integrated care principles on a national policy level takes time, strategy and requires a common vision, as well as allowing autonomy for the discrete parts of the IC system.

4.5 This report is merely the first stage of this realist review as part of the evaluation of the Regional Integration Fund. The realist review will continue across Year Two of the project (2024-25) utilising the methods outlined above to further expand the review and shed further light on the research questions. This will enable a nuanced and more comprehensive understanding of the literature around integrated care, which will further enable the research team to provide a comprehensive evaluation of the RIF.

Appendices

Appendix 1: Data for Consolidated CMOCs

CMOCs were grouped (mainly by outcome or context/theme) to identify patterns across the extracted data (If – then statements). This resulted in the following consolidated CMOCs for each research question. NB: Where a paper is not listed, this is because it did not fit into a superordinate theme or bucket code across the data for that question.

The table is split into three columns: The paper details, and whether the CMO works for IC or doesn't work for IC e.g. enablers and barriers.

Q1. What are the core components of integrated health and social care models and innovations that become sustainable, how and why, for whom, and to what extent?

Autonomy and Sustainability		
Paper	**CMO Works**	**Doesn't Work**
Q1R4 (PAPER 2)	(C) Integrated care partnerships rely on networks based on professional autonomy in the context of reliability. (M) This allows team workers roles and scope to be clear in integrated care programmes. (O) This avoids misunderstandings, and ensures efficient collaboration between care providers, which means that person-centred care can be achieved.	
Q1R5 (PAPER 3)	(C) Development of integrated care schemes in response to rising health costs and complex patients in a bureaucratic health care system. (M) Level of fiscal autonomy of specific integrated care programme and individual hospitals within the programme. (O) greater programme sustainability where greater autonomy occurred.	
Q1R6 (PAPER 3)	(C) Attempt to achieve sustainability of integrated care programmes. (M) Program A wanted each hospital to have greater autonomy and fiscal responsibility. (O) This meant that results were not diluted across a	

	shared bundle, and sustainability was more evident.	
Q1R7 (PAPER 3)	(C) Attempt to achieve sustainability of integrated care programmes. (M) Programme B opted for a retrospective gains and loss sharing agreement. (O) Enabled programme B to exert control over financial uncertainty.	
Co-location, collaboration, communication		
Paper	**CMO Works**	**Doesn't Work**
Q1R9 (PAPER 4)	(C) Attempt to foreground practical interdisciplinary teamwork. (M) decision made to co-locate all health and social services in co-run centres. (O) Enabled continuous learning and service integration.	
Q1R12 (PAPER 5)	(C) Limited capacity of exercise training facility. (M) Less than 20% of estimated patient demand covered. (O) Prompted two types of multi-model prehabilitation programmes: physical activity-based programme, and a face-to-face supervised exercise training programme.	
Q1R14 (PAPER 7)	(C) Foregrounding integrating person-centred communication as a key competency of person-centred-integrated care (PC-IC). (M) Use of open communication, communication based on equality, what matters to patient, use of evidence-based information tailored to patients needs, relational communication techniques for family members, good listening skills. (O) Improved person-centred communication and care	
Q1R15 (PAPER 7)	(C) Foregrounding interprofessional communication as part of PC-IC. (M) Healthcare organisations showing good communication skills towards external organisations. (O) Improved inter-professional communication for PC-IC	

Common Vision		
Paper	**CMO Works**	**Doesn't Work**
Q1R10 (PAPER 4)	(C) equal importance was given to all of the service users' needs (medical, psychological, social etc.).(M) Brought about a shared holistic view on service users and, consequently, an identified need to organise health and social care in a cohesive manner. (O) Enabled the creation of a shared vision and strategy formulation, which in turn set the direction for the organisation and its priorities.	
Q1R13 (PAPER 6)	(C) The Morayfield Health Precinct (MHP) engaged in the community business and clinical environment. (M) This common vision being embedded within planning and implementation processes enabled effective healthcare for patients in the area. (O) This contributes to MHP serving over 200,000 patients in an efficient, safe and appropriate manner (7 days/week, 12 h/day, 365 days per year).	

Barriers to Integrated Care		
Paper	**CMO Works**	**Doesn't Work**
Q1R8 (PAPER 4)		(C) Emphasis on co-producing care and changing language - 'patient' to 'customer'. (M) This language caused barriers to be raised by national regulators around changing language. (O) Old terms such as 'patient' kept in use.
Q1R11 (PAPER 6)		(C) Evidence based benefits of a clinical intervention demonstrated in a highly controlled setting cannot be generalised to real world scenario (effectiveness). (M) Evidence-based benefits of a clinical intervention demonstrated in a highly controlled setting (efficacy) very often cannot be generalised to the real-world scenario (effectiveness) within the same site.

		(O) Creates phenomenon efficacy-effectiveness gap.

Quality of Evidence		
Paper	**CMO Works**	**Doesn't Work**
Q1R3 (PAPER 1)	(C) Digging into black box of change process to strengthen evidence base of integrated care. (M) Embedding process evaluations and logic models for evaluation of integrated care models. (O) Strengthens evidence base of IC.	

Q2. How and why do integrated health and social care models and innovations successfully become mainstreamed, for whom, and to what extent?

System Integration		
Paper	**CMO Works**	**Doesn't Work**
Q2R3 (PAPER ONE)	(C) Investigation of characteristics of domains of integrated care. (M) Found that Co-ordination of back office and support functions across all units is an important factor in IC.(O) Results in functional integration as a domain of integration.	
Q2R4 (PAPER ONE)	(C) Six characteristics were identified in the literature that shared a common theme associated with patient care. (M) One of these was the Use of patient-centred approaches and typical patient case profiles as a driver of design care and delivery. (O) More successful integrated health and social care services (IHSCs).	
Q2R5 (PAPER TWO)	(C) A pernicious issue within the secondary care sector: the episodic and uncoordinated care of non-emergency patients in NHS hospitals, particularly in the case of complex, multi-morbid patients. Academics attempt to find existing clinics that offer	

	integrated holistic person-centred care as examples to solve this issue. (M) Mayo clinic cited as one of best global examples of integrated holistic clinics - physicians from every medical speciality work collaboratively to meet individual patient needs, often during the same patient visit. (O) Because of this collaboration, Every Mayo patient is assigned a coordinating physician whose job is to ensure that the patient has an appropriate plan of care, that all ancillary services and consultations are scheduled in timely fashion to meet the patient's needs, and that the patient receives clear communication throughout.	
Q2R9 (PAPER FOUR)	(C) Co-occurring mental health and substance misuse disorder treatment has previously been fractured. (M) Lead to the implementation of integrated treatment programmes. (O) These were effective in treating co-occurring mental health and substance misuse disorders.	
Collaboration Between Discrete Parts of Health Sector		
Paper	**CMO Works**	**Doesn't Work**
Q2R6 (PAPER THREE)	(C) Patients with a suspected non-acute cardiac complaint, who would usually be referred to secondary care, were now discussed during the Support Consultation. (M) As part of the Support Consultation model, a Cardiologist is assigned to specific primary care practice and visits every four weeks, to discuss non-acute patients. (O) Face-to-face interaction at primary care facility with GP and cardiologists enables effective teamwork due to closed-loop communication and mutual trust.	

Q2R7 (PAPER THREE)	(C) Cardiologist coaches GP to deal with patient cardiac issues. (M) GP function as gatekeeper was strengthened by the advice of the cardiologist. (O) Potential net saving of 61 per cent due to new model.	
Q2R22 (PAPER THIRTEEN)	(C) Use of integrated care models in CAMHS. (M) Triggered the use of paediatric collaborative care in CAMHS. (O) Improves patient outcomes to a modest extent.	
Q2R25 (PAPER SIXTEEN)	(C) What Models of integrated care in behavioural health are more effective? An investigation into the literature. (M) A more effective model is one where a specialist in behavioural health becomes a part of the total medical health system. (O) Specialist BH clinics are connected to and are within the same system as medical clinics and services, leading to improved referral and communication methods for patients and practitioners.	
Person-Centred Integrated Care		
Paper	**CMO Works**	**Doesn't Work**
Q2R10 (PAPER FIVE)	(C) What are the core components of person-centred integrated care with a health promotion public health approach. (M) One core component is co-ordination of integrated care in a culturally responsive way. (O) This creates individualised care that is reactive to the needs of a defined population.	
Q2R11 (PAPER FIVE)	(C) Issues of Population health and quality of life for people with dementia. (M) Led to the creation of dementia-friendly pharmacies in an integrated manner to try and improve quality of life. (O) Created enabling environments	

	that respect dignity and can become more personalised.	
Barriers to Integrated Care		
Paper	**CMO Works**	**Doesn't Work**
Q2R12 (PAPER SIX)		(C) Implementation of a National Programme for Diabetes. (M) For some GPs there was a breakdown of GP contract negotiations. (O) GPs perceived new programme as undermining their practices and resources.
Q2R23 (PAPER FOURTEEN)		(C) Approaches to conceptualising integrated care. (M) There is an assumption of aligned patient and system perspectives. (O) This leads to faulty conceptualisations of integrated care.
Integrated Care Data		
Paper	**CMO Works**	**Doesn't Work**
Q2R13 (PAPER SEVEN)	(C) Use of integrated information systems has required a shift in thinking to viewing the healthcare system as a whole. (M) Social care information officers are now getting to grips with hospital data and hospital analysts are interpreting primary out of hours service provision. (O) In order to successfully discharge patients from an acute bed, a broad range of support services need to be understood to avoid readmission.	
Q2R14 (PAPER SEVEN)	(C) The Derbyshire Digital House of Care initiative created to test the concept of integrating health and social care data. (M) Because of the work of the DDHC, the Derbyshire Health and Social Care Community embraced integrated data and erosion of organisational boundaries. (O) Provided unique insights into population need, service redesign and pathway outcomes, resulting in opportunities for the evaluation	

	and commissioning of services in a joined-up way.	
Q2R15 (PAPER SEVEN)	(C) Issue of falls in elderly people in Derby area. (M) Clinical audit of falls admissions in Royal Derby Hospital in those aged 65 plus. (O) The digital house of care and resulting audit offered professionals an enhanced understanding of this patient cohort.	
Q2R20 (PAPER TWELVE)	(C) Big Data provides options to evaluate integrated care. (M) One option presented by Big Data is that it proposes model development occurs simultaneously to testing. (O) This approach allows the researcher flexibility to adjust models of the intervention, adding or removing variables as their relevance becomes more or less apparent.	
Q2R21 (PAPER TWELVE)	(C) Big Data provides options to evaluate integrated care. (M) Shift to dynamic modelling and testing using Big Data. (O) Helps to assess capacity of variables to produce emergence of feedback loops under certain circumstances.	
Autonomy		
Paper	**CMO Works**	**Doesn't Work**
Q2R16 (PAPER EIGHT)	(C) Poor morale within nurses in Dutch care system who had been given managerial tasks that diverted them from direct care tasks. (M) In an attempt to redress this, Buurtzorg tries to incentivise good care and an appropriate use of resources by organising staff in small self-managed teams of 8 to 12 nurses and nurse assistants covering a geographical patch that they themselves choose. (O) Team has maximum autonomy to deliver the quality of care it wants to provide and to organise itself	

	for best possible client outcomes. This means overall management overheads are low compared to alternative approaches.	
Q2R17 (PAPER NINE)	(C) Young people in the Children and Young Peoples Secure Estate often present with high-risk behaviours directed both towards themselves and others, and who are also vulnerable in terms of their emotional well-being and the potential for exploitation from others. (M) This led to the implementation of smaller, stable units of frontline staff attached to smaller residential groupings of young people. (O) These smaller units allow that group of frontline staff to get to know in detail a particular group of young people, so that they can hold in their minds information about those young people's lives outside the estate, become experts in how those young people function within the estate and develop relationships with those young people that can be used as vehicles of change.	
Measuring Integrated Care		
Paper	**CMO Works**	**Doesn't Work**
Q2R19 (PAPER ELEVEN)	(C) How to measure the depth of true integration. (M) Measured by the level of support and expansion of (1) integrated governance and partnerships; (2) integrated workforce and staffing; (3) integrated financing and payment and (4) data-sharing and use. (O) Measuring using these parameters provides an accurate measurement of true integration of health and social care.	
Q2R24 (PAPER FIFTEEN)		(C) Under investigation of specific dimensions of integrated care in existing literature. (M) Research into dimensions of integrated care shows the fundamental structure of a health

		system may influence the decision to measure parts rather than the whole of integrated care. (O) Not one comprehensive instrument found that measured all the relevant dimensions of integrated care.

Q3. What are the core components for the implementation of national government policy and funding schemes for integration/integrated health and social care?

National, Regional & Local Integrated Care Policy		
Paper	**CMO Works**	**Doesn't Work**
Q3R3 (PAPER ONE)		(C) In the 1980s, home based services and provision of welfare equipment were the local government's responsibility. (M) This caused sectionalism and bureaucracy in local government. (O) Delayed the delivery of integrated home care services.
Q3R4 (PAPER ONE)	(C) Mitsugi town had a larger proportion of bedridden population than Hiroshima prefecture until 1983. (M) This lead to the implementation of the community-based integrated care system. (O) Ten years later the figure of bed-ridden older people had fallen and stabilized at one per cent.	
Q3R5 (PAPER ONE)	(C) Medical care costs in Mitsugi were high. (M) specialist care at home prevented common conditions among the bedridden, such as aspiration pneumonia, urinary tract infections and decubitus ulcers. (O) Medical care costs for the elderly in Mitsugi fell, however this does not account for long term care costs.	
Q3R6 (PAPER ONE)	(C) Need for national integrated system to deal with high rates of bedridden adults and high community care costs. (M) National policy makers notice Mitsugi integrated care system slowed growth of healthcare costs and decreased proportion of bedridden elderly. (O) Integrated community care system was applied on a national	

	policy level based on Mitsugi system success.	
Q3R9 (PAPER FOUR)	(C) Development of Dutch national model Care for Obesity. (M) Extensive use made of science, policy and practice expertise available from other organisations. (O) Resulted in a science and practice-based model, thereby improving the development of the national model in all its facets.	
Q3R10 (PAPER FIVE)		(C) Access policies to arthroplasty in England and implications for IC. (M) High variation in BMI policy stringency between regions in England. (O) Caused inequality to patient access to arthroplasty.
Q3R13 (PAPER SEVEN)	(C) Investigation of integrated care policy making. (M) Found that there is evidence to show that characterising integrated care innovation in a standardised fashion can improve policy.(O) Creates a common language allows policy makers to better understand reforms and innovations designed to improve integrated care.	
Q3R14 (PAPER SEVEN)	(C) Investigation of integrated care policy making. (M) codifying or characterising these complex interventions in a way that is meaningful and useful to those being asked to adopt them. (O) Improves chances of policy makers to spread and scale up integrated care innovations.	
Barriers to Integrated Care		
Paper	**CMO Works**	**Doesn't Work**
Q3R7 (PAPER TWO)		(C) Implementation of integrated care in mental health and alcohol and drug services. (M) During implementation, it is noticed that empirical evidence supporting effectiveness of integrated care is still emerging and not comprehensive. (O) Service providers may be reluctant to commit their resources and training opportunities to integrated care due to lack of evidence.

Integrated Care Frameworks		
Paper	**CMO Works**	**Doesn't Work**
Q3R8 (PAPER TWO)	(C) Develop a framework for uptake of IC to help with the transition to IC. (M) Uptake of service innovations driven by frontline staff with leadership from consumers and support from management. (O) Framework for sustained uptake of IC service innovations more likely to facilitate the embedding of research evidence into clinical practice.	
Q3R11 (PAPER SIX)	(C) Decision making around ICS implementation and the configurations of systems and places for ICS. (M) Agreement between health and local government of the 'best' spatial configurations of systems and 'places'. (O) Helped to ensure clarity of governance arrangements.	
Q3R12 (PAPER SIX)	(C) The reconciliation of system and individual responsibilities. (M) This caused a shift from competition to collaborative working. (O) Reconciliation of system and individual responsibilities was improved.	
Q3R16 (PAPER NINE)	(C) New Care Models programme introduction. (M) Use of Vanguard sites to broker and support relationships within different layers of the IC system. (O) Helped build trust, gain a shared understanding of the programme and its goals, share emerging learning, and support communication.	
Q3R17 (PAPER NINE)	(C) New Care Models programme introduction. (M) Development of communities of practice. (O) Helped to broker and sustain developing IC relationships.	
Q3R18 (PAPER TEN)	(C) Integrated care implementation. (M) Use of change management principles. (O) Successful implementation of integrated care programmes.	

Peer Support in Integrated Care		
Paper	**CMO Works**	**Doesn't Work**
Q3R15 (PAPER EIGHT)	(C) Group based sessions for patients with obesity and mental health issues. (M) Participation in group-based sessions. (O) Encouraged opportunities for peer interactions with people with similar experiences.	

Appendix 2: Literature Database Excerpt

Article Information				Theory Building				
Author	Date	Title	Source	Paper Aim	Context	Mechanism	Outcome	Superordinate Theme
DESCHODT, M., LAURENT, G., CORNELISSEN, L., YIP, O., ZÚÑIGA, F., DENHAERYNCK, K., BRIEL, M., KARABEGOVIC, A. and DE GEEST, S.	2020	Core components and impact of nurse-led integrated care models for home-dwelling older people: A systematic review and meta-analysis.	International journal of nursing studies, 105, pp. 1.	Systematic review of nurse-led integrated care interventions for multi-morbid older people	Digging into black box of change process to strengthen evidence base of integrated care	Embedding process evaluations and logic models for evaluation of integrated care models	Strenghtens evidence base of integrated care	Quality of evidence
RASKU, T., KAUNONEN, M., THYER, E., PAAVILAINEN, E. and JORONEN, K.	2019	The core components of Community Paramedicine – integrated care in primary care setting: a scoping review	Scandinavian Journal of Caring Sciences, 33(3), pp. 508-521	Scoping review	Integrated care partnerships rely on networks based on professional autonomy in the context of reliability	This allows team workers roles and scope to be clear in integrated care programmes	This avoids misunderstandings, and ensures efficient collaboration between care providers, which means that person centred care can be achieved	Autonomy
Embuldeniya, G	2021	The reimagination of sustainable integrated care in Ontario, Canada	Health Policy (HEALTH POLICY), Jan2021; 125(1): 83-89. (7p)	Qual Research on integrated care funding schemes in Ontario Canada	Development of integrated care schemes in response to rising health costs and complex patients in a beaureucratic health care system	Level of fiscal autonomy of specific integrated care programme and individual hospitals within the programme	Greater programme sustainability where greater autonomy occurred	Autonomy
Embuldeniya, G	2021	The reimagination of sustainable integrated care in Ontario, Canada	Health Policy (HEALTH POLICY), Jan2021; 125(1): 83-89. (7p)	Qual Research on integrated care funding schemes in Ontario Canada	Attempt to achieve sustainability of integrated care programmes	Program A wanted each hospital to have greater autonomy and fiscal responsibility	This meant that results were not diluted across a shared bundle, and sustainability was more evident	Autonomy
Embuldeniya, G	2021	The reimagination of sustainable integrated care in Ontario, Canada	Health Policy (HEALTH POLICY), Jan2021; 125(1): 83-89. (7p)	Qual Research on integrated care funding schemes in Ontario Canada	Attempt to achieve sustainability of integrated care programmes	Program B opted for a retrospective gains and loss sharing agreement	Enabled program B to exert control over financial uncertainty	Autonomy
Klinga, C	2018	Understanding the dynamics of sustainable change: A 20-year case study of integrated health and social care	Klinga et al. BMC Health Services Research (2018) 18:400	History of integrated health and social care in an area of Sweden	Emphasis on co-producing care and chanigng language - 'patient' to 'customer'	This language caused barriers to be raised by national regulators around the changing language	Old terms such as 'patient' kept in use	Barriers
Klinga, C	2018	Understanding the dynamics of sustainable change: A 20-year case study of integrated health and social care	Klinga et al. BMC Health Services Research (2018) 18:400	History of integrated health and social care in an area of Sweden	Attempt to foreground practical interdisciplinary teamwork	Decision made to co-locate all health and social services in co-run centres	Enabled continuous learning and service integration	Co-location, collaboration, communication
Klinga, C	2018	Understanding the dynamics of sustainable change: A 20-year case study of integrated health and social care	Klinga et al. BMC Health Services Research (2018) 18:400	History of integrated health and social care in an area of Sweden	equal importance was given to all of the service users' needs (medical, psycho logical, social etc.)	Brought about a shared holistic view on service users and, consequently, an identified need to organise health and social care in a cohesive manner	Enabled the creation of a shared vision and strategy formulation, which in turn set the direction for the organisation and its priorities	Common vision
Baltaxe, E	2022	Role of Co-creation for Large-Scale Sustainable Adoption of Digitally Supported Integrated Care: Prehabilitation as Use Case	International Journal of Integrated Care, 2022; 22(4): 1, 1–12.	Evidence based benefitis of a clinical intervention demontstrated in a highly controlled setting cannot be generalized to real world scenario (effectiveness)	Evidence-based benefits of a clinical intervention demonstrated in a highly controlled setting (efficacy) very often cannot be generalized to the real-world scenario (effectiveness) within the same site.	Creates phenomenon efficacy-effectiveness gap	Major obstacle in demonstrating health value generation	Barriers
Baltaxe, E	2022	Role of Co-creation for Large-Scale Sustainable Adoption of Digitally Supported Integrated Care: Prehabilitation as Use Case	International Journal of Integrated Care, 2022; 22(4): 1, 1–12.	The current report describes the co-creation process undertaken (2016–2021) to deploy a prehabilitation service at Hospital Clínic de Barcelona with the final aim of achieving sustainable adoption and facilitate site transferability	Limited capacity of exercise training facility	Less than 20% of estimated patient demand covered	Prompted two types of multi-modal prehabilitation programmes: physical activity based programme, and a face-to-face supervised exercise training program.	Co-location, collaboration, communication
Oprescu, F	2023	Transforming Primary Care: Developing Health Precincts as Models for Sustainable Integrated Community-Based Healthcare	Healthcare, 11, 673	This case report focuses on successful com ponents of a private, integrated, patient-centred primary care model located in a low socioeconomic population in North Brisbane, Queensland	The Morayfield Health Precinct (MHP) engaged in the community business and clinical environment.	This common vision being embedded within planning and implementation processes enabled effective healthcare for patients in the area	This contributes to MHP serving over 200,000 patients in an efficient, safe and appropriate manner (7 days/week, 12 h/day, 365 days per year)	Common vision
				Chronic disease management is important in primary care. Disease management programmes focus primarily on				

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